RFTOP 674-08-0034

STATEMENT OF WORK AND EVALUATION CRITERIA

PROCUREMENT SENSITIVE DOCUMENT

HIV Prevention Interventions for Most at Risk Populations and related Organizational Capacity Building

BOTSWANA

BOTSWANA: Support for the HIV Response in Botswana within the Civil Society, for HIV Prevention Interventions that Target Most-At Risk Populations

1. PURPOSE

The U.S. Government (USG) is implementing the President's Emergency Plan for AIDS Relief ("Emergency Plan") strategy in numerous countries. The goals of the Emergency Plan strategy, worldwide, are to:

- Prevent 7 million new HIV infections;
- Treat at least 2 million HIV-infected people; and
- Care for 10 million HIV-affected individuals and orphans and vulnerable children affected by HIV and AIDS

The Emergency Plan is a $15 billion, 5-year unified government initiative, directed by the Office of the Global AIDS Coordinator in the Department of State (OGAC), and implemented in collaboration with the U.S. Department of State (DOS), the U.S. Agency for International Development (USAID), the Department of Health and Human Services (HHS), the Department of Defense (DOD), and other U.S. Government Agencies. Fourteen countries were initially selected to be part of the initiative based on high HIV burden, available country resources, and host government and civil society commitment to fighting the HIV epidemic. USG agencies operating in Botswana include the State Department (Embassy), USAID, the DOD, Peace Corps and the U.S. Centers for Disease Control and Prevention (CDC).

The purpose of this Task Order is to improve the quality and quantity of services available to Most-at-Risk Populations in Botswana and to strengthen the organizational capacity of local service organizations to provide such services. In Botswana, key MARP populations include, among others, female sex workers, clients of sex workers, women who are engaged in transactional and/or cross-generational sexual relationships, mobile populations (e.g. truckers, farm workers), and employees of uniformed services. The Applicant would not be expected to target all such groups but rather select some key MARP populations that a limited set of local organizations can reasonably target for quality interventions.

In order to maximize the potential for program sustainability, USAID has included provision for substantial sub-Agreements to local partners, and strongly encourages Applicants to incorporate significant participation of Botswana NGOs including community-based organizations (CBOs) and faith-based organizations (FBOs), in their plan to achieve the results. The selection of the local partners may happen after the initial award, to allow for time for the prime partner to understand the local context and potential partners. In such cases, the Applicant should describe its proposed method of partner selection and draft criteria for selection. Final selection of local partners would be done in collaboration with other local stakeholders and USG representatives.

Offerors should develop program descriptions for a five-year period to begin October 1, 2008 and end September 30, 2013 for a total estimated cost of $6,533,000.

2. TASK ORDER BACKGROUND

2.1 Botswana Country Context

HIV/AIDS remains one of the most important social and public health problem in Botswana. The country is experiencing one of the most severe HIV/AIDS epidemics in the world, affecting both urban and rural areas with equal weight. According to the Botswana AIDS Impact Survey (2004), 25% of adults were HIV infected.

According to the Botswana 2005 Second Generation HIV/AIDS Surveillance data, HIV prevalence among pregnant women aged 15-49 years was 33.4 %. The highest prevalence was recorded in Selebi-Phikwe (47%) while the lowest was in Goodhope (21%). In at least 13 districts, HIV prevalence was over 30% and in all the remaining 10 districts had HIV prevalence between 20% and 30%. The highest age specific prevalence of 49.2% was observed among women aged 30-34 years. There was no significant difference in HIV prevalence between urban and rural districts. A general population survey, the Botswana AIDS Impact Survey of 2004 found a prevalence of 17% among individuals ages 18 months to 99 years. With so many adults of productive age infected with HIV, the epidemic is not only a severe health crisis, but also a threat to the future development and viability of Botswana as a nation.

Within the Government of Botswana (GOB), there is a high level of commitment to addressing the epidemic, with strong leadership from the President, His Excellency Mr. Festus G. Mogae. The response continues to expand through consistent and increasing resource allocation by the government, building upon the base of a strong health infrastructure and guided by national priorities and strategies, including the National HIV/AIDS Strategic Framework (NSF) and HIV/AIDS related goals contained within the nation's development blueprint, Vision 2016. Among the government's many achievements are Botswana's distinction as a the first African country to offer free ART to its citizens; its high PMTCT uptake and effectiveness; and its unique routine (provider-initiated) HIV-testing program.

Despite the use of a multi-sectoral approach and current support provided by various development partners and government agencies, civil society has untapped resources, skills, and energy for the national response to HIV/AIDS in Botswana, particularly for expanding the reach of HIV/AIDS prevention, care and support services to communities. Many non-governmental organizations lack resources, in addition to programmatic technical skills and management capacity. Most grassroots organizations at the community level have not registered as formal entities with the Registrar of Societies, and the sector as a whole is small and without a collective voice in the national agenda. Many small and medium-sized businesses are also at a disadvantage for participating effectively in the national HIV response. For Botswana to achieve its national goals for

HIV/AIDS, the non-governmental sector will require significant strengthening in leadership, coordination, organizational development and service delivery.

The USG is one of the lead development partners helping Botswana to address its HIV/AIDS epidemic. The USG collaborates with numerous local partners, including the National AIDS Council (NACA) and other relevant Government Ministries such the Ministry of Health, Ministry of Local Government, Ministry of Education among others. This collaboration has led to formulation and application of national norms and standards for prevention of mother-to-child transmission (PMTCT), counseling and testing (CT), anti-retroviral treatment (ART), among other achievement. Through the Emergency Plan, the USG will continue to partner with GOB, bringing technical expertise and financial support to help Botswana maximize the quality, coverage, and impact of its own national response.

2.2 Background on "Most at Risk Populations" (MARPs) in Botswana

Although Botswana's epidemic is generalized, there are sections of the population that are most at risk of acquiring and transmitting HIV. According to a *Rapid Assessment of STI Care Seeking Behaviour among Selected High Risk Groups of Migrant Populations* conducted in 2006 by the Ministry of Health, these sections play an important role in the STI (including HIV) transmission in their communities. They also play an important role in maintaining high STI transmission rates among the bridging populations and through them keep STI widespread in the general population (p.2).

The *Botswana National Strategic Framework for HIV/AIDS 2003 – 2009* lists broad groups of youth and children, women, orphans, the poor, mobile populations and people living with HIV and AIDS as groups that require priority in segmentation for interventions (p.17). This strategic document acknowledges the importance of addressing the needs of each of these groups with targeted interventions. The more recent *National Strategy for Behaviour Change Interventions and Communications for HIV and AIDS* produced by the National AIDS Coordinating Agency (NACA) notes that there is still much to be done with regards to targeting prevention interventions to the specific issues and needs of key groups, including MARPs (p.6). A team of consultants has been engaged by NACA, with the assistance of African Comprehensive HIV and AIDS Programme (ACHAP), to draw a work plan with which the BCIC strategy will be operationalised. This effort will likely result in a new statement for priorities for interventions, including those for MARPs. The Contractor will be expected to follow such developments and align the program to such national priorities.

The US President's Emergency Plan for AIDS Relief (PEPFAR) provides its own list of key MARPs, which includes incarcerated populations, injecting drug users, men who have sex with men, military populations, mobile populations, non-injecting drug users, persons in prostitution, persons who engage in transactional sex but who do not identify as persons in prostitution, and street youth. While some of these are not critical to HIV transmission in Botswana (e.g. injecting drug users), this list and other information

provide a base from which to help identify critical MARP in Botswana. While there are few data to guide designation of MARP in Botswana, it is felt that the following are likely important candidates for inclusion:

- Commercial sex workers and their clients
- Women 15 - 29 in transactional and/or cross-generational relationships
- Mobile populations (employees of disciplined forces, tour companies, trucking companies, the ministry of agriculture, and construction companies).

Commercial Sex Workers

In Botswana like many countries, sex work is illegal but active. Approximate figures of the sex worker population are unavailable and difficult to assess because of women's movement in and out of sex work, migration across Botswana, stigma associated with sex work, and overlap with transactional sexual relationships. According to the recent *HIV Needs Assessment of Female Sex Workers in Major Towns, Mining Towns, and Along Major Roads in Botswana* conducted in 2006 by the International Education and Training Center on HIV (I-TECH), female sex work exists across the country but varies in its visibility, organization, and solidarity. It is driven by a variety of factors, including limited opportunities for other paying jobs for many women, high status placed on multiple sex partners among men, and low wages for both men and women. Condom use is inconsistent in sex work and represents one of many risks that women take as sex workers. Sex workers reported that health care services were available and equitable for them but not targeted specifically to them, a view echoed by health care providers themselves as well.

Many organizations provide services to commercial sex workers as part of the general population but only two organizations identified in the assessment provide services specifically to sex workers: Matshelo Community Development Association (MCDA) in Francistown and Nkaikela in Tlokweng. Some districts have initiated special clinics for sex workers, their clients, and other high risk populations (Kasane and Francistown areas), but these efforts had not yet been implemented in full at the time of the study. The assessment identifies a number of areas for intervention for consideration, to reduce entry into sex work, reduce risks among those engaged in sex work, and to facilitate exit from sex work for those women wanting an alternative.

Women 15 - 29 years old in cross-generational and/or transactional relationships

Results of the *BAIS II* survey show a relatively low HIV prevalence among both boys and girls between ages 1 – 14. From age 15 - 24, there is a marked leap in HIV prevalence for women, quadrupling that of men. Although some physiological factors contribute to this disparity, it is thought that cross-generational and transactional relationships between younger women and older men play an important role in it. These relationships are, according to one journalist, "motivated by physical attraction, emotional rapport and financial calculation. But the last of these seems to have particular weight in Botswana, where 'transactional' sexual relationships, in which

women expect gifts of cash or consumer goods from boyfriends, are by many accounts extremely common," (Epstein, H. *The fidelity Fix*, New York Times, June 13, 2004. p.7).

Data on cross-generational relationships are few, but one study of 600 high school girls in Gaborone found that 60% of them reported they had friends or relatives who had older boyfriends, and that 39% reported they had been approached by older men in the past. Fifty-four of the total sample, or 33% of those who had been approached by an older man, had had sex with a man at least 10 years older (Nkosana 2006). While not all cross-generational sex is risky for the women and girls involved, often it is. In Nkosana's study, condom use was inconsistent within cross-generational relationships, and coercive and unplanned sex was more common among those girls in cross-generational relationships compared to their sexually-active counterparts not in such relationships. The main motivation for such relationships reported by girls was to obtain money for lifestyle goods.

A *Population-Based Study on Alcohol and High Risk Sexual Behaviours in Botswana (Ministry of Health 2004)* "demonstrate[s] a strong and consistent relationship between heavy alcohol use and a number of risky sexual behaviours among both men and women, and the important link between sex exchange and heavy alcohol use" (p.12). The same study found a very high prevalence of heavy alcohol use in samples of both rural and urban individuals in Botswana (p.12). Alcohol abuse was also a common theme in the recent sex worker HIV needs assessment and is likely to be important to most MARPs in Botswana.

Other MARP

Men who have Sex with Men (MSM) exist in Botswana, but there no reliable figures about the size of that population. Sex between men is not accepted nor acknowledged as part of most Botswana communities. There are concerns that identifying as homo/bi-sexual is illegal and that targeting such an audience with services or risk reduction programs is as well (a similar sense affects the availability of programs for sex workers as well). As a result, MSM are rarely noted as key groups within national HIV/AIDS strategies, despite the high risk for HIV and other STI such individuals often face. In response to this, the Lesbians, Gays and Bisexuals of Botswana (LeGaBiBO) was formed to advocate for the establishment of a legal framework to reach those in society who are socially marginalized because of their sexual orientation. This group is supported by Botswana Network of Ethics, Law and HIV/AIDS (BONELA).

Without much additional data, it is difficult to characterize other Most at Risk Populations. Some likely groups, like soldiers and officers in the Botswana Defense Force (BDF) currently are provided HIV prevention and related services through other initiatives, supported by PEPFAR and, primarily, the Government of Botswana. Other men in uniformed services, truck drivers, and other mobile populations may benefit from some workplace and other community and clinical services for HIV prevention, but there are few other known interventions targeting such groups as MARPs or the venues where high risk sex happens or begins (e.g. shebeens, informal bars, etc.)

3 TASK ORDER APPROACHES

3.1 Summary of the Approaches

The strategy envisioned includes support and strengthening of community-based HIV prevention interventions that target MARPs. Project monitoring and evaluation are expected to underlie all program components.

Component One: Community-based prevention interventions targeting MARPs

Component Two Strengthen technical and organizational capacity of Botswana civil implementing partners to support component one

The outcomes and illustrative activities associated with these components are described in the sections below.

3.2 Approach One: Prevention for MARPs

The contractor will be one of several Emergency Plan partners helping to achieve the "Infections averted" targets. Specifically the objectives are:

- To increase access to quality HIV/AIDS/STI prevention services for Most at Risk Populations in Botswana
- To strengthen the linkages between these services and other critical HIV/AIDS related care and treatment services, such as PMTCT, ARV, VCT, etc.

The prevention component will aim to increase mobilization and effectiveness of Botswana NGO/CBOs/FBOs for community-based HIV prevention activities that target critical MARP groups. More specifically, the Recipient is expected to provide sub-grants and other assistance (technical assistance, organizational development, financial management) to these organizations to help them implement quality prevention interventions for MARPs in the community at large, at high risk venues, or through other interpersonal means. The activities should be guided by best practices for the relevant target populations, the USG's ABC Prevention Guidelines, and the capacity of the implementing organizations.

Target populations for this component may include: sex workers, clients of sex workers, girls ages 15-29 involved in cross-generational relationships, and mobile populations, among others. The specific target groups will be determined in consultation with USG representatives and stakeholders from the Government of Botswana and other agencies and organizations, including the Contractor. Correct and consistent condom use, effective use of available health care and other support services, sexual partner reduction, and alcohol abuse reduction/prevention are likely to be critical HIV prevention themes in these interventions.

Illustrative strategies and activities to help achieve the Emergency Plan Program Outcome targets for Prevention include, but are not be limited to:

- Identification and adaptation of appropriate intervention models for application in Botswana and with the selected local implementing partner and target population(s). Such models may include peer education programs, the development of informal support networks among individuals who are Most at Risk of HIV transmission and infection, and approaches based on popular opinion leader theories of change. It is likely that most activities will be interpersonal and small group in focus, given the target populations. Mass media interventions are not likely to be a focus of this program. Adaptation, translation, and pilot testing of relevant interventions and/or tools for application in Botswana are encouraged.

- Support for the implementation and expansion of such interventions by the local implementing partners, including training, technical assistance (TA), provision of supportive materials, and operational sub-agreements to those local partners. The local partners may require fairly intensive technical assistance to ensure high quality service delivery, including periodic on-the-job supervision and support, study tours (if fully justifiable), process evaluation, and other means. The Contractor should be prepared to provide support for organizational capacity in such areas as facilitation skills, training, peer outreach, curriculum adaptation and implementation, service referrals, IEC development, integration of alcohol abuse into HIV prevention, and project monitoring and quality assurance to their partner organizations.

- TA and training to strengthen and formalize referral systems between those organizations serving MARPS and other related community and clinical services to support more comprehensive service. Clinical services in Botswana are fairly strong and available, and every effort should be made to strengthen linkages among those and organizations serving MARP. It is not expected that the community organizations delivering HIV prevention interventions will also provide all critical services, such as HIV testing and STI screening. In such cases, real and effective referrals are essential. The Contractor may need to help develop referral systems with the local partners and help operationalize them in meaningful ways.

- Collaboration with other relevant local coordinating structures to foster increased coordination of community HIV outreach efforts that target MARPs and related groups. In this regard, the Contractor is expected to link with important coordinating bodies such as the District Multi-Sectoral AIDS Committees, national-level coordinating and technical committees, and District Health Teams, to ensure that the organizations and activities are known, acceptable, and leveraged to the extent possible. Involvement in relevant advocacy or policy-making efforts, as they occur, may also be included in this component of the project. In addition, the Contractor is expected to promote discussion, exchange, and group learning among its local partner organizations through periodic workshops, retreats, and other means of communication.

- Monitoring of the quality and extent of implementation as well as project evaluation for some components of the project. Process evaluation is essential to this component, as is routine monitoring (outlined further below). Outcome evaluation is not required at this stage and can be considered only once organizational capacity is considered sufficient and program implementation considered of high enough quality to merit such. Focus should begin with faithful implementation of high quality evidence- and/or theory-based prevention programs, and include simultaneous monitoring of these efforts.

Expected Results

In the long term, the program should help reduce transmission of HIV among key most-at-risk populations. In the short term, the program should expect to have results such as the following, while noting that the specific results will vary by the target population:

- Increase in knowledge and use of condoms (correctly and consistently) among MARP and their partners
- Increase knowledge of linkages between alcohol use and HIV/AIDS, risk perception associated with drinking and sex, and reduction in risky drinking and related behaviors
- Increase in risk perceptions associated with multiple and concurrent sexual partners, decrease in the number of partners
- Increase in knowledge and use of relevant health care services, including HIV testing, STI treatment, ART, PMTCT, and other health and social services
- Decrease in physical, emotional risks and harm that some MARP face, such as personal safety and violence
- Increase in individuals' motivation for, access to, and use of school, job skills and opportunities, savings programs, safer forms of recreation
- Increase in the social support that MARP have, as groups and within communities

3.3 Approach Two: Technical and Organizational Capacity Building

The Contractor is one of several Emergency Plan partners contributing to capacity building of Botswana organizations. No proportional funding has been allocated; rather, the Recipient is expected to pro-rate funding from Component 1 as necessary to achieve results. This proportion is expected to be substantial, though, given average implementation capacity of local NGOs, CBOs, and FBOs in Botswana.

More specifically, the Contractor is expected to provide capacity building to its local partners in both programmatic/technical as well as organizational/administrative areas. The aims are to ensure adequate project oversight and accountability, to support future viability of those organizations, and to assure that organizational staff and volunteers are fully equipped and supported to delivery high quality interventions in their relevant

contexts. The specific technical assistance provided will vary according to the needs of the local implementing partners working with the Contractor. The Contractor should be prepared to tailor the activities accordingly.

Illustrative activities might include, but not be limited to:

- Development, testing, refinement, and dissemination of successful models of community- and/or venue-based prevention activities for MARPs
- Development of recommended personnel staffing patterns and position descriptions and development of training materials for such positions.
- Development/adaptation/codification of training and BCC materials
- TA and training to develop procedures and practices to enhance transparency and accountability and improve constituent outreach (e.g. Boards, other donors, other community groups and coordinating bodies)
- TA and training in financial systems development and institutional quality control (personnel policies and supervision, administrative systems and controls, program monitoring and evaluation)
- On-the-job, consultative, and formal training sessions, as required, for the individual organization and for groups of organizations with common needs.

Expected Results

The intended outcome of this component is at bottom, to increase the number of organizations that can deliver high quality HIV/AIDS interventions and programs over a longer term. In the short term, expected results may include:

- Increase in organizational capacity of a select group of NGOs, such that they can better compete for funding in the future and manage such funding well
- Increase in the quality of the interventions such organizations carry out (e.g. use of promising or proven program models), and their ability to innovate independently towards higher quality
- Increase in the organizations' program monitoring skills and practice, including process evaluation and output monitoring
- Increase in the organizations' linkages with related organizations, services, and coordinating bodies; use of those linkages for program improvement, coordination, and advocacy

4. Deliverables: Proposed Indicators, Monitoring and Evaluation, and Reporting

4.1 Indicators

USAID HIV/AIDS funds are subject to the Emergency Plan requirements, thus the successful applicant will, at a minimum, report on all relevant PEPFAR indicators.

Additional program indicators may be developed for more detailed program monitoring and reporting to the CTO.

Below are some illustrative indicators. Additional indicators should be developed by the Contractor in collaboration with the CTO based on short- and long-term results like those listed above. Contractors are also encouraged to submit qualitative data on program achievements and results.

Illustrative Process Indicators:
- Identification of promising HIV prevention interventions that can be realistically applied in the Botswana context
- Organizational development plans drafted

Illustrative Output Indicators:
- Number of comprehensive programs that address the risk factors (e.g. economic empowerment, HIV/AIDS awareness) implemented.
- Increased range of services offered to MARP
- Number of MARP participating in comprehensive programs
- Number of local organizations, service providers, and community members trained

Illustrative Outcome Indicators:
- Significant decrease in HIV risk behaviors of select MARP

4.2 Monitoring and Evaluation

The contractor will be responsible for developing and executing a Monitoring and Evaluation (M&E) plan, in consultation with the CTO and the USG in-country PEPFAR team. Expected program results with illustrative indicators, mid-term milestones/benchmarks, end-of-project results should be elaborated in the M&E plan. Data sources and collection methodologies should also be noted for each indicator. As stated above, the contractor is also encouraged to submit qualitative data on program achievements and results.

During the initial program planning period, the contractor shall work closely with the CTO and the USG in-country PEPFAR team to establish final indicators, as well as baseline data and performance targets for each indicator. The M&E plan shall be submitted to the CTO for approval within 30 days of the award of the Task Order. USAID and the successful applicant will conduct periodic performance reviews to monitor the progress of work and the achievement of results as based on the targets specified in the M&E plan. Financial tracking data will be required on a quarterly basis, as described below. The contractor and CTO must also seek approval from the USG team for all planned activities.

Any program evaluation protocols (design, methods and components) developed as part of this program may be sent to the PEPFAR Public Health Evaluation team (PHE) for review and comment.

4.3 Reporting

a. Implementation Plan: The contractor shall develop a detailed plan of implementation for the life of the project. The implementation plan shall clearly outline the programmatic approach as described in this contract, and provide a timeline for the completion of results and deliverables. The contractor will be responsible for ensuring that the implementation plan is developed in coordination with the USG PEPFAR teams in Botswana. A Year One Implementation plan shall be submitted to the CTO for approval within 30 days of the award of the Task Order. The contractor and CTO must also seek approval from the USG team for all planned activities.

b. Monitoring and Evaluation Plan (see Monitoring and Evaluation above)

c. Country-specific PEPFAR reporting requirements: The contractor shall comply with all country-specific PEPFAR reporting requirements, including but not limited to Annual and Semi-Annual Performance reports and annual Country Operational Plan submissions. The contractor will be responsible for ensuring that all of the country-specific PEPFAR reporting requirements are met.

d. Quarterly financial and progress reports should contain, at a minimum, the following:
    a. Total funds awarded to date by USAID into the task order;
    b. Total funds previously reported as expended by Contractor by main line items;
    c. Total funds expended in the current quarter by the Contractor by main line items;
    d. Total unliquidated obligations by main line items; and
    e. Unobligated balance of USAID funds.
    f. Program achievements and activities of the quarter
    g. Barriers encountered and overcome
    h. Plans for following quarter

e. Short-term consultants' reports shall be submitted to the CTO in a mutually agreed upon format and time frame.

f. Special reports: From time to time, the contractor may be required to prepare and submit to USAID special reports concerning specific activities and topics.

g. Completion report: At the end of the task order, the contractor shall prepare a completion report which highlights accomplishments against work plans, gives the final status of the benchmarks and results, addresses lessons learned during implementation and suggests ways to resolve constraints identified. The report may provide recommendations for follow-on work that might complement the completed

work. The Contractor(s) are also encouraged to publish the program experiences in peer-reviewed journals, if applicable.

All products and deliverables will be in the public domain. The contractor will not have copyright on these products.

5. Personnel

5.1 Key Personnel

Offerers must specify the positions that should be designated key personnel and provide resumes and biodata sheets (From AID 1420-17) for the candidates proposed for such positions. Specify the qualifications and abilities of proposed key personnel to successful implementation of the proposed technical approach. Each resume shall be accompanied by a signed letter of commitment from each candidate indicating his or her availability, intention to serve, agreement to the compensation levels set forth in the cost proposal. When key personnel (e.g. in-country managers) have not been identified, offerors should describe how they will go about selecting such individuals and the criteria for selection.

USAID reserves the right to adjust the key personnel during the performance of this task order.

6. Instructions to Offerors

6.1 Technical Proposal

The length of the technical proposal shall not exceed 25 pages, with single line spacing and standard one inch margins. The proposal should be submitted electronically and the software compatible with Microsoft Office. The Appendices are excluded from this page limit. Offerors should organize the proposal according to the evaluation criteria noted below.

The technical proposal must set forth in sufficient detail the conceptual approaches and techniques for implementing the task order activities outlined above. The proposal should demonstrate knowledge of the Botswana context, from epidemiology to existing Emergency Plan team (and other development agencies') partners' potential roles in this task order. The proposal should include a realistic draft implementation plan, which links clearly to intended outcomes of this program.

Cover page (1 page)

A single page with the names of the organizations involved in the propose program. Subcontractors should be listed separately. The Cover Page should include names of the proposed Project Director, Organizational affiliation, name of a contact person for the prime offeror and his or her contact information.

Executive summary (2 pages)

This summary should summarize the key elements of the offeror's technical strategy, management approach, implementation plan, and expected results.

Technical approach (up to 12 pages)

This section should include a brief country assessment relevant to this task order, as well as a concise description of the proposed technical strategy, including approaches to service delivery for MARP in a context like Botswana and to comprehensive capacity building to local civil society organizations.

Personnel (up to 3 pages)

This section should summarize roles, responsibilities, and qualifications of key personnel, local and expatriate, to be funded under this task order. Resumes, biodata, and letters of commitment should be included separately (noted above).

Management approach (up to 5 pages)

This section should summarize how the offeror will manage the task order, including the approach to potential problems. Specify the roles and responsibilities of each organization noted in the proposal, and exactly how the project team will be structured. Offerors may proposed a mix of international and domestic advisors and specialists, and must include substantial involvement of local (Batswana) staff in project management. Offerors should describe the process of identifying, selecting, and managing local implementing partners, in the case that these have not been identified yet.

6.2 Cost Proposal

There is no page limit on the Cost Proposal. Offerors should submit a summary cost proposal for a 5 year operating period. The following minimum cost breakdown should be provided: Salary and wages, with detailed LOE; fringe benefits; Consultants; Travel; Transportation and per diem; Equipment and supplies; Subcontractors and Participant Training; Other Direct Costs; G&A; Material Overhead; any other Indirect Costs. Provide a copy of the organization's NICRA if applicable. The budget should be accompanied by budget notes that provide sufficient detail to allow for a budget analysis.

7. Evaluation Criteria

The criteria listed below are presented by major category, so that offerors will know which areas require emphasis in the preparation of the technical proposal. Offerors should note that these criteria serve as the standard against which all technical information will be evaluated, and serve to identify the significant matters which offerors

should address. In this case, each category will be weighted equally (20 points X 5 areas = 100 points). .

1. Technical Understanding and Approach to the Statement of Work (20)

The extent of the offerors' understanding of and feasibility/ability to successfully perform the activities as described in the Statement of Work, including:

- Country assessments, including: epidemiological context; assessment of risk factors, gender issues and potential for program linkages
- Use of appropriate technical strategies and methodologies for the two programmatic components (MARP interventions + organizational/technical capacity building)
- Approaches to service delivery
- Ability to collaborate across sectors

2. Technical Approach to Capacity Building Component (20)

The offerors' experience with and stated approach to:

- Organizational development
- Technical assistance for high quality program implementation

3. Quality of Personnel (20)

Demonstrated ability to gain access to appropriate technical personnel that demonstrates technical experience and expert qualifications in all the programmatic areas outlined in the Statement of Work. Representation of in-country technical staff or specific plans for such.

4. Management Approach (20)

- Assessment of the prime and major subcontractors' demonstrated depth and breadth of experience in areas identified in the Statement of Work
- Ability of the Prime to develop an in-country presence and ability to effectively manage efforts in-country, including ongoing coordination with the USG in-country PEPFAR team.
- Depth of organizational experience in managing relevant projects
- Ability to simultaneously and transparently manage task orders involving collaborative efforts drawing upon the full range of available skills and experience of the Offeror, and maintain clear and effective lines of communication between and among clients, technical, administrative, and logistical project staff.

5. Past Performance (20)

Past performance assessment will focus on the offeror's demonstrated: (i) Timeliness of performance, including adherence to contract schedules, timely delivery of short-term technical advisors, and effectiveness of home and field office management to make

prompt decisions and ensure efficient operation of tasks; (ii) Cost control; (iii) Quality of products or services, including how cooperative and effective the Prime was in fixing problems; (iv) Customer satisfaction, including satisfactory business relationships with clients, prompt and satisfactory correction of problems, and cooperative attitude in fixing problems; (v). Documented past success in implementing and achieving results in technical programs similar to those described in the SOW; and, (vi) Effectiveness of key personnel, including effectiveness and appropriateness of personnel for the job, and prompt and satisfactory changes in personnel or deliverables when problems were identified either by the Contractor or by the client.

END OF SOW AND EVALUATION CRITERIA